Supreme Court, U.S.
FILED

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No.

IN THE

Supreme Court of the United States

JOHN R. CONNOR, Executor of
The Estate of Helen T. Hanlon, Deceased,

Petitioner,

-v-

TOMMY G. THOMPSON, Secretary of the
Department of Health and Human Services,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE THIRD CIRCUIT

PETITION FOR WRIT OF CERTIORARI

JOHN R. CONNOR
Executor, Estate of
Helen T. Hanlon,
Petitioner pro se
380 Wyoming Avenue
Millburn, NJ 07041
(973) 762-5587

(8086 – 2005)
Printed on Recycled Paper

QUESTIONS PRESENTED FOR REVIEW

1. Whether 42 CAR §405.817(a)(1), the Social Security Administration's regulation which defines the "amount in controversy" for purposes of an appeal to an Administrative Law Judge, which regulation is formulated for the purpose of establishing Medicare's remaining potential liability on a benefits claim, can be applied to a beneficiary who is arguing that there is *no* liability *per se* on the claim, either on the part of Medicare or the beneficiary, without violating Due Process and Equal Protection guarantees in the United States Constitution?

2. Whether 42 U.S.C. §405(h)'s prohibition of 28 U.S.C. §1331 (federal question) actions can be applied to a beneficiary who is *not* seeking to recover a monetary benefit from Medicare; and, alternatively, whether jurisdiction can be otherwise asserted herein under 28 U.S.C. §1331, 42 U.S.C. §405(g) or 42 U.S.C. §1395ff(b)(2)(B)?

LIST OF ALL PARTIES

The parties to the proceedings below were:

1. John R. Connor, Executor of the Estate of Helen T. Hanlon, Deceased – plaintiff-petitioner.

2. Tommy G. Thompson, Secretary of the Department of Health and Human Services – defendant-respondent.

3. Jo Anne B. Barnhart, Commissioner of the Social Security Administration – defendant (dismissed in accordance with district court's Order dated December 11, 2003). (App. G, *infra*, p. 29a)

TABLE OF CONTENTS

Page

Questions Presented for Review i

List of all Parties ii

Table of Contents iii

Table of Authorities vi

Opinions Below 1

Jurisdiction 1

Constitutional Provisions, Statutes, Regulations, and Court Rules Involved 1

Statement of the Case 4

A. Factual and Procedural Background 4

B. The District Court's Opinion 13

C. The Court of Appeals' Opinion 16

Reasons for Granting the Writ 21

I. Petitioner estate has a colorable constitutional claim with respect to its challenge to 42 U.S.C. §405.817(a)(1), as written and applied *infra*, under the Supreme Court's decision in Bowen v. Mich. Academy of Family Physicians, 476 U.S. 667 (1986) 21

Page

II. Federal judicial review of the within matter can be sustained under 28 U.S.C. §1331, 42 U.S.C. §405(g) or 42 U.S.C. 1395ff(b)(2)(B) (2001) 30

Conclusion 33

Appendix A - Opinion of the Court of Appeals for the Third Circuit 1a

Appendix B - Judgment of the Court of Appeals for the Third Circuit 8a

Appendix C - Opinion of United States District Court, District of New Jersey 10a

Appendix D - Order of United States District Court, District of New Jersey 20a

Appendix E - Sur Petition for Rehearing of Court of Appeals for the Third Circuit 22a

Appendix F - Opinion of United States District Court, District of New Jersey 24a

Appendix G - Order of United States District Court, District of New Jersey 28a

Appendix H - Order of Dismissal of Office of Hearings and Appeals , Social Security Administration 30a

Appendix I - Action of Medicare Appeals Council on Request for Review of Dismissal 33a

Page

Appendix J - Decision of Office of Hearings and Appeals, Social Security Administration 35a

Appendix K - Action of Medicare Appeals Council on Request for Review 40a

Appendix L - Decision of Medicare Fair Hearings 43a

Appendix M - Decision of Medicare Fair Hearings on Motion for Reconsideration 50a

Appendix N - DNR "Do Not Resuscitate Order," dated March, 31, 2000 ..... 59a

TABLE OF AUTHORITIES

Cases: **Page**

Abbey v. Sullivan, 978 F.2d 37 (2nd Cir. 1992) 15

American Ambulance Service v. Sullivan,
911 F.2d 901 (3rd Cir. 1990) 32

Aquavella v. Richardson, 437 F.2d 397
(2nd Cir. 1971) 15

Bartlett v. Heckler, 576 F.Supp. 830
(D.C. Cir. 1983) 14, 31

Bonner v. Couglin, 517 F.2d 1311 (C.A. 7, 1975) 14

Bowen v. Michigan Academy of Family Physicians,
476 U.S. 667 (1986) ..... *passim*

Califano v. Sanders, 430 U.S. 99 (1977) 24

Clarinda Home Health v. Shalala, 100 F.3d 526
(8th Cir. 1996) 25

Fanning v. U.S., 346 F.3d (3rd Cir. 2003) 25

In Re Complaint of Bankers Trust Co., 752 F.2d 874
(3d Cir. 1984) 14

Johnson v. Robinson, 415 U.S. 361 (1974) 22, 31

Matthews v. Eldridge, 424 U.S. 319 (1976) 30

McCuin v. Secretary of Health and Human Services,
817 F.2d 161 (1st Cir. 1987) 31

Page

Medical Fund-Philadelphia Geriatric Center v. Heckler, 804 F.2d 33 (3rd Cir. 1986) 32

Michigan Academy of Family Physicians v. Blue Cross and Blue Shield of Michigan, 502 F.Supp. 751 (E.D. Mich. 1980) 20

Michigan Academy of Family Physicians v. Blue Cross and Blue Shield of Michigan, 728 F.2d 326 (C.A. 6, 1984) 21

Mitchell v. Occidental Ins. Medicare, 619 F.2d 28 (9th Cir. 1980) 18, 19, 27

Paratt v. Taylor, 451 U.S. 527 (1981) 14

Shalala v. Illinois Council on Long Term Care, Inc., 529 U.S. 1 (2000) ..... *passim*

Weinberger v. Salfi, 422 U.S. 749 (1975) 22

Constitutional Provisions, Statutes, Regulations and Court Rules:

United States Constitution:
Fifth Amendment ..... *passim*

Statutes: Page

28 U.S.C.:
§1254(1) 1
§1331 ..... *passim*

42 U.S.C.:
§405(b) 23
§405(g) ..... *passim*
§405(h) ..... *passim*
§1395(b)(1982) 21
§1395cc(h) 23
§1395ff(b)(1)(E)(1) 2
§1395ff(b)(2)(B)(2001) ..... *passim*
§1395ii ..... *passim*
§1395x(y)(2)(B) 30
§1395y(a)(1)(A) 2

42 CFR:
§405.504(b)(1985) 21
§405.815 ..... 3, 8, 11, 20
§405.817(a)(1) ..... *passim*

FRCP:
12(b)(1) 9, 10, 13
21 9
59(e) 9

Medicare Carrier's Manual §12016(1985) 21

OPINIONS BELOW

Petitioner seeks review, on his petition for writ of certiorari to the United States Court of Appeals for the Third Circuit, of an adverse Opinion and Judgment rendered by the Third Circuit on October 14, 2004, affirming the Opinion and Order issued by the District Court of New Jersey granting respondent's Rule 12(b)(1) motion for dismissal on October 16, 2003. The Opinion and Judgment rendered by the Third Circuit Court of Appeals is unreported and is set out in full at Appendix A, pages 1-7a, and Appendix B, pages 8-9a. The Opinion and Order of Dismissal issued by the District Court of New Jersey is unreported and is set out in full at Appendix C, pages 10-19a, and Appendix D, pages 20-21a.

JURISDICTION

The judgment of the Court of Appeals for the Third Circuit was entered on October 14, 2004. A timely petition for rehearing was denied on December 16, 2004. This Court's jurisdiction is invoked under 28 U.S.C. §1254(1). The jurisdiction of the District Court was invoked under 42 U.S.C. § 405(g) and 20 CFR §404.981.

CONSTITUTIONAL PROVISIONS, STATUTES, REGULATIONS AND COURT RULES INVOLVED

The Fifth Amendment to the United States Constitution provides in pertinent part:

> No person shall be * * * deprived of life, liberty, or property without due process of law. . .

42 *U.S.C.* §1395ff(b)(2)(B) (2001) provides in pertinent part:

> [U]nder part B of this subchapter, a hearing shall not be available to an individual under paragraph (1)(C) and (1)(D) if the amount in controversy is less than $500 (or $100 in the case of home health services) and judicial review shall not be available to the individual under that paragraph if the aggregate amount in controversy is less than $1,000.[1]

42 *U.S.C.* §1395y(a)(1)(A) states in pertinent part:

> Notwithstanding any other provision of this subchapter, no payment may be made under Part A or Part B of this subchapter for any expenses incurred for items or services * * * which * * * are not reasonable and necessary for the diagnosis or treatment of illness or injury. . .

42 *U.S.C.* §405(g) provides in pertinent part:

> Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision . . .

42 *U.S.C.* §405(h) provides in pertinent part:

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[1] Amended Dec. 21, 2000 and made applicable to initial determinations made on or after October 1, 2002, the hearing requirement is reduced from $500 to $100. (Initial Determination, *infra*, is dated July 31, 2001). 42 U.S.C. § 1395ff(b)(1)(E)(1).

> The findings and decision of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

42 *CFR* §405.815 states in pertinent part:

> Any party designated in Sec. 405.822 is entitled to a carrier hearing after a review determination has been made by the carrier if the amount in controversy is $100 or more * * * To be entitled to a hearing before an ALJ following the carrier hearing, the amount remaining in controversy must be $500 or more, and for judicial review following the ALJ hearing and Departmental Appeals Board Review, the amount remaining in controversy must be $1000 or more.

42 *CFR* §405.817(a)(1) states in pertinent part:

> (a) Individual appellants. For the purpose of determining whether an individual appellant meets the minimum amount in controversy needed for a carrier hearing ($100) or ALJ hearing ($500), the following rules apply:

> (1) The amount in controversy is computed as the actual amount charged the individual for the items and services in question, less any amount for which payment has been made by the carrier and less any deductible and coinsurance amounts in the particular case.

STATEMENT OF THE CASE

The within petition for a writ of certiorari is predicated upon petitioner's Due Process and Equal Protection challenge to a regulation of the Social Security Administration, to wit: 42 CFR §405.817(a)(1), which defines "amount in controversy" for the purpose of a Part B appeal to an Administrative Law Judge.

Petitioner estate contends that the regulation, as written and applied *infra* by the agency is barring the estate from an agency hearing before an Administrative Law Judge on its claim that it owes nothing on a bill, submitted to Medicare, by one of decedent's former physicians. Under the circumstances, the estate will be liable for the bills of no less than two primary care physicians rendered at the same time for the same patient, decedent Helen T. Hanlon.

A. Factual and Procedural Background

Petitioner is the executor of the Estate of Helen T. Hanlon (deceased April 7, 2000). Since March 1, 1996, petitioner had served as Health Care Representative for Helen Hanlon, his cousin. The Proxy Directive granted petitioner, in the event of his cousin's disability, the right to make health care decisions and the authority to "hire and *discharge* physicians to care for [decedent]." (App. C at 11a). (Emphasis added).

Four years later, on March 9, 2000, Helen Hanlon (hereafter referred to as "decedent") was admitted to Overlook Hospital in Summit, New Jersey with symptoms of cardiac insufficiency and remained in the hospital's Intensive Care Unit ("ICU") until her death on April 7, 2000. Id. On or about March 17, 2000, decedent, suffered a Coumadin (blood thinner) bleed in her lower left quadrant, which adversely impaired her kidney function. She became comatose and remained so until her death. Id.

At this time, decedent was under the care of her primary care physician, Susan B. Profeta, M.D., who, following the Coumadin bleed incident, suggested to petitioner that a nephrologist (kidney specialist) be brought in to attempt to medically restart decedent's kidney function. Petitioner agreed to the suggestion and, acting on Dr. Profeta's suggestion, retained Dr. Burton Tucker, M.D. (Medical Diagnostic Associates, P. A.) for that purpose.

After the March 17, 2000 coumadin bleed, Dr. Susan Profeta, on several occasions, asked petitioner to sign a Do Not Resuscitate ("DNR") Order for decedent, which request petitioner consistently declined. A problem with decedent's treatment that occurred on March 27, 2000 involving an attempt to feed decedent via a feeding tube, which procedure had not been discussed with plaintiff beforehand, gave petitioner the impression that Dr. Profeta intended to proceed with decedent's care without consulting petitioner. Shortly thereafter, when petitioner was advised by a hospital staff member that decedent's doctors were planning to perform a bronchoscopy of decedent's lungs, of which procedure petitioner knew nothing, he contacted decedent's attorney who, at his request, on March 28, 2000, sent a letter to Dr. Profeta advising her that petitioner's "consent must be secured *prior* to the performance of any invasive procedures. (App. M at 52a). (Emphasis added).

Immediately thereafter, on March 30, 2000, Dr. Profeta telephoned petitioner to inform him that she was resigning from the case and to get another primary care physician. (App. M at 52a). Petitioner immediately replaced Dr. Profeta as primary care physician with the nephrologist, Burton Tucker, M.D., who accepted the assignment. The following morning, on March 31, 2000, Dr. Profeta encountered petitioner at the hospital and advised that she had had a change of mind and requested to come back on the case. The offer was declined by petitioner who advised Dr. Profeta that Dr. Tucker had "stepped up" to serve as decedent's primary care physician. Id. at 53-54a.

Dr. Tucker's status as decedent's primary care (attending) physician was expressly confirmed in writing on March 31, 2000, when petitioner executed a DNR Order and designated Dr. Burton Tucker as decedent's attending physician. (App N, at 59-60 a). The Order, placed on decedent's chart in I.C.U., ruled out aggressive therapy (chest compressions, shock, etc.) in the event of heart failure. The Order was countersigned by a hospital physician in the I. C. U. unit (Dr. E. Nguyen), and subsequently by Dr. Tucker, himself. Id. The Order was omitted from the copy of decedent's medical records turned over to petitioner and was not given to petitioner until the second Medicare Fair Hearing had concluded the following year on September 20, 2001.

The following month, after decedent's passing, petitioner received an Explanation of Medicare Part B Benefits Statement, dated May 5, 2000, whereon it was shown that Dr. Profeta had submitted to Medicare, and received payment for, eight (8) visits she allegedly made to decedent during the March 30 – April 7, 2000 period, after she had resigned and been replaced by another physician as primary care for decedent. (App. C at 11a). Dr. Profeta later claimed, during the Medicare Fair Hearings' phase of this case, that she could never get in touch with Dr. Tucker to confirm his status as decedent's primary care physician and so,

without petitioner's knowledge or permission, simply remained on the case. (App. M at 54a). (The Medicare billing records of both physicians evidence that both Dr. Profeta and Dr. Tucker had actually attended decedent on the same days of March 30 and March 31, 2000). From March 18, 2000 to April 5, 2000, Dr. Tucker (Medical Diagnostic Associates, P.A.) and his associates attended decedent, billing a total of $1,608.33 to Medicare, which award Petitioner did not contest. However, petitioner did appeal to Medicare Fair Hearings the award of the Medicare carrier (Empire Medical Services) to Dr. Profeta, who had billed Medicare for $640.00 for 8 visits (@ $80.00 per visit, which claim was allowed at .80%, or $487.52, leaving an amount of $121.98 as the estate's obligation, which figure became the "amount in controversy" figure for the next level of appeal to an Administrative Law Judge ("ALJ"). 42 CFR §405.817(a)(1). (App. L at 48a).

The Medicare Fair Hearing ("MFH") on petitioner's appeal of the award to Dr. Profeta took place on July 30, 2001 at 10 a.m. -- at a time when petitioner was midway between Ireland and Newark, New Jersey, returning from a two-week trip to Europe. (App. M at 51-52a). Petitioner had no prior knowledge of the (telephone) hearing. Only one employee (Pilar Kerr) from the billing department of Dr. Profeta's Paramount Medical Group attended. (App. L at 43a). There was no appearance for the estate. Id. Plaintiff forthwith filed a motion for reconsideration with Medicare Fair Hearings, which, in its Initial Decision, had found that "Dr. Susan Profeta was the primary care physician and [that] the documentation supports the billing of the eight subsequent hospital visits in question." (App. L at 47a). Additionally, that the "official transfer of the primary care of the patient [from Profeta to Tucker] never occurred." Id. at 46a.

On September 20, 2001, at 9:00 a.m., Medicare Fair Hearings conducted a telephone "reopening" hearing on

petitioner's reconsideration motion. After the hearing had concluded, there arrived in the mail that afternoon, from Overlook Hospital, a copy of the March 31, 2000 DNR Order (App. N at 59a) appointing the replacement physician (Tucker) that had not originally been turned over to plaintiff when decedent's medical records, totaling 367 pages, were forwarded by the hospital, and which order petitioner had been trying to obtain for the second hearing. The order was received too late to use during the second hearing and does not figure in the second Fair Hearing decision, which denied petitioner's motion for reconsideration. (App. M at 50-58a).

Petitioner appealed both Medicare Fair Hearings decisions (the initial decision and the denial of the motion for reconsideration) to an Administrative Law Judge, who dismissed the appeal for lack of jurisdiction because the "amount in controversy," as computed under 42 CFR §405.817(a)(1) was less than the $500.00 required for an ALJ hearing under 42 CFR §405.815. (App. H at 30-32a). A subsequent appeal to the Medicare Appeals Council was denied for the identical reason on August 16, 2002, which order became the final order of the agency. (App. I at 33a). On October 21, 2002, petitioner filed the complaint in this action in the United States District Court for the District of New Jersey, for review of the agency's August 16, 2002 decision.

Despite the August 16, 2002 Medicare Appeals Council decision barring an ALJ hearing in this matter (App. I at 33a) an ALJ (Dean W. Determan) scheduled and conducted a hearing in Newark, New Jersey on September 17, 2002. On that date, a merits hearing was held wherein testimony was taken, including that of petitioner, the aforesaid Pilar Kerr, and an agency medical expert, Max Yablonsky, M.D. Exhibits were introduced into the record, including the aforementioned DNR

Order.[2] On October 21, 2002, the ALJ declined to issue a decision on the merits, deciding he did not possess jurisdiction in the appeal because the amount in controversy, as calculated by §405.817(a)(1), was less than $500.00. (App. J at 35-39a).

On April 23, 2003, respondent filed a motion in the District Court to dismiss the complaint in this action under FRCP 12(b)(1) for lack of subject matter jurisdiction, specifically arguing that the district court did not possess jurisdiction inasmuch as petitioner did not meet the $1,000.00 "amount in controversy" figure required for judicial review under 42 U.S.C. §1395ff(b)(2)(B). Petitioner opposed dismissal on the ground that the $1,000 minimum did not apply under the circumstance where there was a challenge to the constitutionality of an agency regulation, in this case 42 CFR §405.817(a)(1), which regulation petitioner had challenged on due process grounds before the agency. No oral argument was held on the dismissal motion in the district court.

On October 15, 2003, the district court (Cavanaugh, J.) issued an Opinion and Order granting respondent's motion to dismiss on the grounds that Plaintiff did not satisfy the $1,000.00 minimum for judicial review and, additionally, that "no constitutional claim in fact exists. . . and [that] there is an available forum in [the] New Jersey Superior Court to adjudicate [petitioner's] claims." (App. C at 19a). The court, however, erroneously dismissed petitioner's complaint under FRCP 21, instead of FRCP 12(b)(1). (App. D at 20a).

Petitioner timely filed a Motion to Alter or Amend Judgment, under FRCP 59(e), to change the dismissal from FRCP 21 to FRCP 12(b)(1). Although petitioner specifically

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[2] Petitioner's request for a formal hearing, including testimony under oath, and compulsory attendance for Doctors Profeta and Tucker, was not granted by ALJ Determan.

advised the court in his moving papers that he was not attempting to relitigate or reargue the merits of the case, the district court (Cavanaugh, J.), in a 4-page Opinion, denied what it deemed to be a "motion for reconsideration." (App. F at 24-27a).

Notwithstanding the court's decision, the accompanying Order *granted* petitioner the relief he had requested: 1) a dismissal under FRCP 12(b)(1) and 2) the dismissal of Defendant Commissioner of the Social Security Administration from this case. (App. G at 28-29a).

* * * * * *

Petitioner, as executor of the Estate of Helen T. Hanlon challenged an initial award by the Medicare carrier (Empire Medical Services) to one of decedent's former physicians (Susan Profeta, M. D.), and attempted, unsuccessfully, to appeal that adverse determination to an Administrative Law Judge ("ALJ"). The criteria for determining eligibility for an ALJ hearing is predicated upon the "amount in controversy":

> "To be entitled to a hearing before an ALJ following the carrier hearing, the amount in controversy must be $500 or more, and for judicial review following the ALJ hearing and Departmental Appeals Board Review, the amount remaining in controversy must be $1000 or more."

42 CFR §405.815. Petitioner is not challenging this regulation *per se*, but argues that he meets the $500 requirement because he is challenging the physician's $640.00 bill *in its entirety*. The regulation petitioner is challenging, 42 CFR §405.817(a)(1), defines the formula for computing the amount in controversy accordingly:

> "The amount in controversy is computed as the actual amount charged the individual for the items and services in question, less any amount for which payment has been made by the carrier and less any deductible and coinsurance amounts applicable in the particular case."

Id. As applied in the agency's March 12, 2002 Order of Dismissal the amount in controversy is only $121.98 (App. H at 30-32a).

Plaintiff, however, since the inception of this case, has been contesting the fact that any Medicare monies were paid to Dr. Profeta for the March 30 – April 7, 2000 period in question because this physician had resigned from decedent's case on March 30, 2000 and been replaced by another physician. (App. M at 56a).

Although the Medicare decisions in this case have been adverse to petitioner on this issue, the Hearing Officer at the Medicare Fair Hearings, in her September 25, 2001 decision, allowed that petitioner might well be entitled to an ALJ hearing, when she stated:

> However, I would like to mention that Mr. Connor indicated in his testimony that he felt that he should be entitled to a hearing before an Administrative Law Judge if my decision was to not revise the original hearing decision. He stated that since he was disputing the $640.00 charge and the fact that any Medicare payment was issued, the next level of appeal for him should be based on the billed charge of $640.00.

> I feel that Mr. Connor made an excellent point in computing the amount in controversy for the next level of appeal based on the fact that he was disputing that any Medicare reimbursement was made to Dr. Profeta. Therefore, I am providing Mr. Connor with the information for filing an appeal before an administrative law judge (ALJ). I cannot guarantee that an ALJ will accept the case; only the ALJ has the authority to make that decision.

(App. M at 56-57a). (Emphasis in original).

The narrow scope of 42 CFR §405.817(a)(1) is further highlighted in the October 21, 2002 decision of ALJ Determan who, in discussing the limitations of the "amount in controversy" formula, stated:

> "[t]he formula does not contemplate situations in which a party contends the amount previously approved is too high. It only considers how much has been billed on the claim, how much Medicare has allowed on the claim and how much more Medicare could potentially pay on the claim."

(App. J at 37a). (Emphasis added). These statements by Hearing Officer Canfield (Medicare Fair Hearings) and ALJ Determan evidence the total inadequacy of 42 CFR §405.817(a)(1) to allow for the situation, infra, where a beneficiary is challenging a physician's bill in its entirety and is arguing for either lower approved amounts or, as in this case, no approved amounts at all.

B. The District Court's Opinion

In its October 16, 2003 Opinion and Order (App. C & D at 10-21a), as amended by its Order of December 11, 2003 (App. G at 28-29a), the District Court dismissed the complaint in this action, under FRCP 12(b)(1) (lack of subject matter jurisdiction), not only because petitioner did not meet the $1,000 minimum for judicial review under 42 U.S.C. §1395ff(b)(2)(B) but also because, according to the court, plaintiff was *only* raising a constitutional issue in order to secure judicial review:

> "A plaintiff who fails to satisfy the $1,000 minimum cannot *then* claim that his rights have been violated in order to secure proper subject matter jurisdiction when *no constitutional claim in fact exists.*"

(App. C at 19a). (Emphasis added). The District Court thereby ignored the fact that petitioner has, in fact, been alleging the unfairness of the agency's application of §405.817(a)(1) to this case ever since the second MFH hearing back in September, 2001.

The District Court's 11-page Opinion dealt only in a broad sense with the due process issue, before its conclusory finding that "no constitutional claim in fact exists." Id. There was *no* discussion of how the regulation was adversely impacting the estate's claim to an ALJ hearing -- in fact, the District Court never even *once* mentioned 42 CFR §405.817(a)(1) in its Opinion and the regulation has been at the epicenter of this case before the agency, as its numerous opinions and orders amply attest.

In petitioner's complaint, jurisdiction was asserted under 42 USC §1395ff(b)(2)(B), wherein petitioner, in his opposition papers, claimed he was entitled to a waiver of the $1,000

minimum because he was challenging an agency rule on due process grounds, as well as 28 USC §1331 (federal question jurisdiction). Again, however, at no time in its Opinion did the district court even mention 28 U.S.C. §1331 as a basis for jurisdiction.

In its Opinion, the District Court attempted to distinguish the case herein from one cited by petitioner in his opposition brief, Bartlett v. Heckler, 576 F.Supp. 830 (D.C. Cir. 1983) wherein judicial review under §1331 was allowed for due process and equal protection challenges to a Medicare Act provision wherein the plaintiff's amount-in-controversy figure of $286.00 was well below the $1,000 jurisdictional minimum for judicial review "because plaintiff's claim is based on the constitution and because there is no alternative method of securing judicial review of her claim." Id. at 831. (Emphasis added).

In its Opinion, the District Court, which never mentioned either §405.817(a)(1) or §1331, attempted to distinguish the case *infra* from Bartlett, supra, by invoking the novel theory that "[p]laintiff is not alleging a violation of due process because he is seeking only a post-deprivation remedy for the $121.98 * * * [and] * * * the laws of the State of New Jersey provide avenues for such remedies." (App. C at 18a). (Emphasis added).

In support of its novel "post-deprivation" finding, the District Court creatively relied on an admiralty case (In Re Complaint of Bankers Trust Co., 752 F.2d 874 (3d Cir. 1984)) and two prisoner suits (Paratt v. Taylor, 451 U.S. 527 (1981) and Bonner v. Couglin, 517 F.2d 1311 (C.A. 7, 1975)), ignoring the fact that this "remedy" would pass jurisdiction on Medicare claims from federal to state courts, in violation of the legal fact that petitioner's sole remedy to secure judicial review of the Secretary's decision exists exclusively under federal Medicare statutes, rules and regulations. *See:* 42 U.S.C. §405(g)(h);

Abbey v. Sullivan, 978 F.2d 37 (2nd Cir. 1992). "Where the Medicare Act establishes procedures for review of the Secretary's decision, a court may not review that decision by any other means." Aquavella v. Richardson, 437 F.2d 397, 402 (2nd Cir. 1971). The District Court's boilerplate theory, challenged on appeal by petitioner before the Third Circuit, was neither defended by respondent nor mentioned by the Third Circuit in its Opinion.

C. The Court of Appeals' Opinion

In its Opinion, filed October 14, 2004, the Third Circuit Court of Appeals affirmed the dismissal of the within complaint in this action by the District Court.[3] (App. A at 1-7a). In that Opinion, the Third Circuit presented a flawed version of the facts in this case to the point where the factual predicate is almost unrecognizable.

First, while mentioning that "[o]n March 20 [2000] Dr. Profeta resigned from Hanlon's case," App. A at 2a, *no* mention was made by the appellate court that Profeta was immediately replaced by another doctor (Tucker) as decedent's primary care physician, whose name and important role in the factual predicate are never mentioned in the Opinion.[4] The picture thereby created is one of a doctor (Profeta) who, of her own volition, continued on a case after her resignation simply because there was no other primary care physician present. It buttressess the Third Circuit's citation to a finding in the first

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[3]The Third Circuit judgment affirmed the "judgment" of the District Court (App. B, at 9a), albeit the lower court entered only an Order of Dismissal (App. D at 20a).

[4] Dr. Burton Tucker, M.D. billed Medicare for 7 visits between March 30, 2000 and April 5, 2000 totalling $525.30, of which Medicare paid $420.75, which allowance petitioner did not contest. The Medicare allowance left a balance due of $104.55 as the estate's obligation.

Medicare Fair Hearing decision of July 31, 2000, that " '[s]ince the primary care of Helen Hanlon was never officially turned over to [another doctor], Dr. Profeta had a legal and moral obligation to continue treating and providing comfort measures for this patient until her death.' " (App. A at 2a).

Second, no mention was made by the Third Circuit in its Opinion that a second hearing had to be scheduled by Medicare Fair Hearings because the first one, on July 31, 2000, took place on the same day petitioner was returning from a trip in Europe. And it is in that second hearing decision that Hearing Officer Lorraine Canfield stated that petitioner had "made an excellent point computing the amount in controversy for the next level of appeal based on the fact that he was disputing that any Medicare reimbursement was made to Dr. Profeta." App. M at 57a. That significant statement was not mentioned by the Third Circuit, either.

Thirdly, the Third Circuit omitted any reference in its Opinion to the DNR Order which petitioner executed on March 31, 2000 (App. N at 59-60a), which Order was not produced by Overlook Hospital until it was too late to use in the second MFH hearing on September 20, 2001. This Order is probative of the fact that Dr. Profeta possessed no role, either legal or ethical, in decedent's care after her resignation on March 30, 2000. And although this critical piece of evidence could not be used during the second MFH hearing, it was introduced into the record at the merits hearing conducted by ALJ Dean W. Determan on September 17, 2002. (See: Statement of Facts, infra, at pp. 8-9). Unfortunately, the ALJ hearing that eventually took place in this case was never mentioned by the Third Circuit in its Opinion.

Fourth, the appellate court misrepresents petitioner's position in this case accordingly:

> He argues, however, that he is not subject to the $1000 amount in controversy requirement because his claim does not arise under the Medicare Act, but rather involves a constitutional challenge. Therefore, according to Connor, § 405(h) does not prevent the District Court from exercising § 1331 jurisdiction over his complaint.[5]

Id. at 4-5a. As asserted in petitioner's Third Amended Complaint in this action, federal jurisdiction was alleged not only under 28 U.S.C. §1331 but also under the Medicare Act, 42 U.S.C. §1395ff(b)(2)(B), which jurisdictional claim merited neither mention nor discussion by the Third Circuit.

Aside from the aforementioned factual errors, the Third Circuit's Opinion contains substantive errors of law. To support its proposition that petitioner was relying strictly on federal question jurisdiction, the Third Circuit relied on a series of "channeling" decisions, principally Shalala v. Illinois Council on Long Term Care, Inc., 529 U.S. 1 (2000), which barred §1331 jurisdiction on an original lawsuit challenging certain Medicare regulations. Quoting from Shalala, supra, the Third Circuit stated that "[i]n holding that federal question jurisdiction was barred under § 405(h), as incorporated by § 1395ii, the Court recognized that the 'bar did not preclude constitutional challenges,' but simply 'require[d] that they be brought' under the same 'jurisdictional grants' and 'in conformity with the same standards' applicable 'to nonconstitutional claims arising under the Act," App. A at 5a, which is to say that they had to be first

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[5] 42 U.S.C. §405(h) states that "[n]o action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter." §405(h) is made applicable to the Medicare Act by 42 U.S.C. §1395ii.

presented to or"channeled" through the agency. The Third Circuit concluded that "Connor is required to 'channel' his claim through the review procedures and requirements of the Medicare Act." Id. at 6a. Of course, this is *precisely* what petitioner has been doing in this case since its inception - "channeling" his claim through the review procedures and requirements of the Medicare Act, in order to secure an ALJ hearing on the estate's claim. The agency, in its orders and opinions, has encountered no such problem in recognizing the estate's challenge to 42 CFR §405.817(a)(1).

Not to deny all possible relief to petitioner on his due process claim, the Third Circuit, relying on Shalala, supra, allowed for the possibility of an "exception to §405(h)'s bar in those cases where no judicial review is available at all." (App. A at 6a). The Third Circuit concluded, however, that the exception to the exhaustion requirement of administrative review was not available to petitioner because "Connor's failure to state a colorable constitutional claim precludes application of the Michigan Academy exception," id. at 7a, wherein the Supreme Court held that " 'a serious constitutional question' . . . would arise if we construed § 1395ii to deny a judicial forum for constitutional claims arising under Part B." Id.

Although the Third Circuit, in contrast to the district court, actually mentioned 42 CFR §405.817(a)(1) in its Opinion, it effectively confused the regulation at issue with §405.815, which establishes the various cutoff figures for levels of appeal following the carrier hearing ($500 for ALJ hearing; $1000 for judicial review) thereby creating the impression that petitioner was challenging this §405.817:

Citing Mitchell v. Occidental Ins. Medicare, 619 F.2d 28, 30 (9th Cir. 1980), the appellate court summarized the case accordingly as:

> "holding that $100 'cutoff for a right to a [carrier] hearing does not violate the Equal Protection Clause because Congress had a rational basis for this limitation,' namely the elimination of the administrative burden created by adjudication of small Medicare claims."

(App. A at 7a). However, petitioner is not challenging the $500 or $1,000 cutoffs in either the statute, 42 U.S.C. §1395(b)(2)(B), or its implementing agency regulation, 42 CFR §405.815. Petitioner *is* challenging §405.817(a)(1)'s method of computing the amount in controversy, which determines eligibility for an ALJ hearing, under circumstances where a beneficiary is challenging the propriety of the entire billing in question. In other words, and in this case, petitioner is claiming that he *meets* the $500.00 requirement for purposes of an ALJ hearing and he is being barred from same by a regulation designed for another purpose, i.e., establishing how much more Medicare would be liable for on the claim in the event of further appeal. Accordingly, petitioner is claiming that this regulation cannot *rationally* be applied to petitioner's facts and circumstances, wherein he claims the right to challenge the doctor's $640 bill, in its entirety.

The above issues were presented to the Third Circuit in a Petition for Rehearing, which the appellate court denied on December 16, 2004. (App. E at 22-23a).

REASONS FOR GRANTING THE WRIT

I. Petitioner estate has a colorable constitutional claim with respect to its challenge to 42 U.S.C. §405.817(a)(1), as written and applied herein, under the Supreme Court's decision in Bowen v.

Mich. Academy of Family Physicians, 476 U.S. 667 (1986).

In Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667 (1986), the Supreme Court decided a case which, in several respects, closely parallels the estate's case, *infra*. The one major exception is that petitioner's case, *infra,* is not a "channeling" case and, hence, the case is not cited for that purpose. Otherwise, Michigan Academy, supra, supports the estate's Due Process and Equal Protection challenge to 42 U.S.C. §405.817(a)(1).

In Michigan Academy, supra, respondent physicians filed an original suit under 28 U.S.C. §1331 (general federal-question jurisdiction) challenging the validity of 42 CFR §405.504(b)(1985), which regulation authorized payment by Medicare in different amounts for similar physicians' services. The District Court, in ruling the regulation invalid, held:

> There is no basis to justify the segregation of allopathic family physicians from all other types of physicians. Such segregation is not rationally related to any legitimate purpose of the Medicare statute. To lump MD's who are family physicians, but who have chosen not to become board certified family physicians for what-ever motive, with chiropractors, dentists, and podiatrists for the purpose of determining Medicare reimbursement defies all reason.

Michigan Academy of Family Physicians v. Blue Cross and Blue Shield of Michigan, 502 F.Supp. 751, 755 (E.D. Mich. 1980). (Emphasis added). (The District Court, ruling the regulation invalid on statutory grounds, did not decide the respondents' constitutional claim). The Court of Appeals for the Sixth Circuit affirmed, holding that the regulation "irrational

and * * invalid." Michigan Academy of Family Physicians v. Blue Cross and Blue Shield of Michigan, 728 F.2d 326, 332 (C.A. 6, 1984). (The appellate court also did not decide respondents' constitutional claims).

The Government in Michigan Academy, supra, argued that Congress had precluded judicial review of all questions involving the "amount of benefits" under Part B of the Medicare program. Under 42 U. S.C. §1395ff(b) (1982), claimants under Part B, in contrast to Part A, were not authorized judicial review as to "amount of benefits." Id., at 673. Further, the Government contended that 42 U.S.C. §1395ii (1982) made applicable 42 U.S.C. §405(h) of the Social Security Act to the Medicare program. And under §405(h), "[n]o action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to *recover on any claim* arising under this subchapter." Id. at 679 (Emphasis added).

In sustaining jurisdiction under 28 U.S.C. §1331, the Supreme Court found that "the reticulated statutory scheme * * * simply does not speak to challenges mounted against the *method* by which such amounts are to be determined rather than the *determinations* themselves." Id. at 675. (Emphasis added). The Court also added: "[a]s the Secretary has made clear, 'the legality, constitutional or otherwise, of any provision of the Act or regulations relevant to the Medicare program' is not considered in a 'fair hearing' held by the carrier to resolve a grievance related to a determination of the amount of a Part B award." Id. at 675-676. In support of its position, the Court cited to the Medicare Carrier's Manual §12016 (1985), which states that the "[h]earing officer * * * is to comply with all the provisions of title XVIII of the Act and regulations issued thereunder * * * [and] * * * may not overrule the provisions of the law or interpret them in a way different than HCFA does when he disagrees with their intent." Id. at 676, note 5.

The Court, in Michigan Academy, supra, found it "implausible to think [Congress] intended that there be *no* forum to adjudicate statutory and constitutional challenges to regulations promulgated by the Secretary." Id. at 678. (Emphasis in original). Additionally, the Court stated: "[b]y the same token, matters which Congress did *not* delegate to private carriers, such as challenges to the validity of the Secretary's instructions and regulations, are cognizable in courts of law." Id. at 680. (Emphasis in original). Further, the Court held that:

> "[W]e will not indulge the Government's assumption that Congress contemplated review by carriers of 'trivial' monetary claims * * * but intended no review at all of substantial statutory and constitutional challenges to the Secretary's administration of Part B of the Medicare program."

Id. at 680. The Court, citing Weinberger v. Salfi, 422 U.S. 749, 762 (1975) (citing Johnson v. Robinson, 415 U.S. 361, 366-367 (1974)) stated that its disposition in Michigan Academy, supra, "avoids the 'serious constitutional question' that would arise if we construed §1395ii to deny a judicial forum for constitutional claims arising under Part B of the Medicare program." Id. at 681, at Note 12.

Finally, the Court addressed the physicians' constitutional challenges to Medicare regulation §405.504(b) with these words:

> "Finally, we cannot, as the Government would have us, dismiss respondents' constitutional attack as insubstantial – that is to say, 'essentially fictitious,' 'obviously frivolous,' and 'obviously without merit' – under *Hagans v. Lavine*,

> 415 U.S. 528, 537 (1974) (internal quotations omitted), as would be necessary to decline jurisdiction over the case. Both courts below found the classification embodied in the regulation to be 'irrational,' see *supra*, at 668-669, and although this finding was made with respect to respondents' statutory claims, it surely casts sufficient doubt on the constitutionality of the classification under the Due Process and Equal Protection Clauses to merit resolution of the constitutional challenge.

Id. at 681-682, Note 12. (Emphasis added).

Bowen v. Michigan Academy, supra, was decided by the Supreme Court on June 9, 1986. four months later, Congress amended the Medicare Act to allow Part B claimants the same administrative and judicial review remedies previously available to Part A claimants, subject to certain amount-in-controversy thresholds, for services rendered after January 1, 1987.

Subsequently, in Shalala v. Illinois Council on Long Term Care, Inc., 529 U.S. 1 (2000), the Supreme Court revisited the issue of whether 42 U.S.C. §405(h) barred federal court jurisdiction under §1331. The appellants in Shalala, supra, had filed an original §1331 suit prospectively challenging, on statutory and constitutional grounds, certain Medicare regulations that tightened the standards Medicare imposes on nursing homes. The Supreme Court ruled that in this case, "the statutory provision at issue, §405(h), as incorporated by §1395ii, bars federal-question jurisdiction here," id. at 5, and that the "association or its members must proceed instead through the special review channel that Medicare statutes create. See 42 U.S.C. §§ 1395cc(h), (b)(2)(A), 1395ii; §§405(b, (g), (h)." Id.

In its Opinion, the Supreme Court found that the Michigan Academy "methodology" exception was not available to appellants, who, post-1987 amendments to Part B claims, were now eligible for further administrative and judicial review, beyond the previously-allowed carrier "fair hearing." The Court, while not reversing its Michigan Academy ruling, restated it's holding accordingly:

> Regardless, it is more plausible to read *Michigan Academy* as *holding* that § 1395ii does not apply § 405(h) where application of § 405(h) would not simply channel review through the agency, but would mean no review at all.

Shalala, supra, at 19. (Emphasis in original). The Court found that the "no review at all" caveat did not apply to appellants, who could present their case to the agency prior to federal court review: "[t]he Council's members remain free, however, after following the special review route that the statutes prescribe, to contest in court the lawfulness of any regulation or statute upon which an agency determination depends. The fact that the agency might not provide a hearing for that *particular contention*, or may lack the power to provide one, see Sanders, 430 U.S., at 109 [Califano v. Sanders, 430 U.S. 99 (1977)] ("Constitutional questions obviously are unsuited to resolution in administrative procedures. . .") * * * is beside the point because it is the 'action' arising under the Medicare Act that must be channeled through the agency. See *Salfi, supra*, at 762. After the action has been so channeled, the court will consider the contention when it later reviews the action. And a court reviewing an agency determination under §405(g) has adequate authority to resolve any statutory or constitutional contention that the agency does not, or cannot decide (citations omitted)." Shalala, supra, at 23. "At a minimum, however, the matter must

be presented to the agency prior to review in a federal court. This the Council has not done." Id. at 24.

In its Opinion, the Third Circuit variously found that: "Connor is required to 'channel' his claim through the review procedures and requirements of the Medicare Act," App. A at 6a; and, "the Michigan Academy exception is not available because Connor has failed to state a colorable constitutional claim." Id. at 7a. The appellate court's Opinion is predicated upon the false premise that petitioner has not already "channeled" the estate's challenge to 42 CFR §405.817(a)(1) through the agency when, in fact, that claim has exhaustively gone through the agency Medicare review route, at *every* level, from the "fair hearing" stage up to and including the Medicare Appeals Council and *been ruled on.* See: Appendices H, I, J, K, L, and M at 30-58a. Consequently, the Third Circuit's reliance on the "channeling" cases is egregiously erroneous. See: Clarinda Home Health v. Shalala, 100 F.3d 526 (8th Cir. 1996) (Exception to exhaustion requirement not available); Fanning v. U.S., 346 F.3d 386 (3rd Cir. 2003) (Federal question jurisdiction not available to class action plaintiff's who did not proceed through special review channel Medicare statutes created).

In contrast to the Third Circuit's statement that petitioner has failed to "state a colorable constitutional claim," App. A at 7a, petitioner submits that the Supreme Court's discussion of the constitutional challenge in Michigan Academy, supra, validates the estate's challenge, infra. In the estate's case, as in Michigan Academy, petitioner is challenging a Medicare regulation, 42 U.S.C. §405.817(a)(1), on constitutional (due process and equal protection) grounds under 28 U.S.C.

§1331.[6] As previously explained in petitioner's Statement of Facts, infra at p. 13, the regulation contains *no* alternative provision for a beneficiary who elects to challenge the entirety of a physician's bill or, as stated by Medicare Fair Hearings: "the fact that any Medicare payment was issued." (App. M at 56a).

Not to overlook ALJ Determan's comment that "[petitioner] has a colorable argument concerning satisfaction of the amount in controversy requirement." (App. J at 36a). ALJ Determan succinctly summarized the limitations of the agency's "amount in controversy" formula in his decision:

> "The formula does not contemplate situations in which a party contends the amount previously billed is too high. It only considers how much has been billed on a claim, how much Medicare has allowed on the claim and how much more Medicare could potentially pay on the claim."

(App. J at 37a). Thus, there is no room in §405.817(a)(1) for beneficiaries who elect to challenge the (100%) totality of an award to a physician by Medicare. Petitioner submits that since the propriety of the entire ($640) billing was "the" issue before Medicare Fair Hearings, then that issue needs remains "the" issue on further appeal to an ALJ in this case.

Aside from the fact that the estate is liable for *another* primary care physician's bill (Tucker), in order for the estate to

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[6] Petitioner also cited 42 USC §1395ff(b)(2)(B) in the estate's Third Amended Complaint as a basis for jurisdiction, predicated upon a waiver of the $1,000 threshold for judicial review. The issue was not addressed by the Third Circuit.

void its (20%) liability under the entire ($640) bill, of necessity it must challenge the bill in its (100%) entirety, and not any (20%) part thereof, which, as computed by Medicare, amounts to $121.98.[7]

In its Opinion, the Third Circuit cited to the case of Mitchell v. Occidental Ins. Medicare, 619 F.2d 28 (9th Cir. 1980) holding that "[the] $100 'cutoff for a right to a [carrier] hearing does not violate the Equal Protection Clause because Congress had a rational basis for this limitation,' namely the elimination of the administrative burden created by adjudication of small Medicare claims." (App. A at 7a). The citation is inapposite because the estate, in its challenge to §405.817(a)(1) is not challenging the $100 (fair hearing), the $500 (ALJ hearing) or the $1,000 (judicial review) cutoff figures. Petitioner estate is, in fact, claiming that it meets, as well as, exceeds the $500 threshold for administrative review due to its challenge to the entirety of the $640.00 physician's bill. The estate is challenging the *method* whereby that cutoff figure is arrived at under §405.817(a)(1) in petitioner's facts and circumstances.

What the Supreme Court is confronted with, *infra*, is a case of first impression insofaras there is no previous case, of record, involving a constitutional challenge to §405.817(a)(1), certainly on the grounds that petitioner is advancing, i.e., a challenge to the 100% entirety of Medicare's award to a physician versus a beneficiary attempting to increase its award from Medicare. However, the Court's opinion in Michigan Academy, supra, comes sufficiently close to be precedential, not only in its allowance of a §1331 challenge to a Medicare

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[7] "The amount in controversy in this case as defined by statute and regulation, is $121.98 [actual amount charged ($640) less payment made by carrier ($487.52) less any deductible ($0) or coinsurance ($0)]. Since the amount in controversy is less than $500, there is no right to a hearing before an Administrative Law Judge." App. H at 31-32a.

regulation but also in its characterization of the lower courts' finding with respect to the challenged classification, which bears repeating:

> "Both courts below found the classification embodied in the regulation to be 'irrational' * * * and although this finding was made with respect to respondents' statutory claims, it surely casts sufficient doubt on the constitutionality of the classification under the Due Process and Equal Protection Clauses to merit resolution of the constitutional challenge.

Id, at 682, Note 12. Petitioner estate submits that if the "lumping" of family physicians with chiropractors, dentists and podiatrists for Medicare reimbursement purposes merited resolution of the constitutional challenge to §405.504(b) in Michigan Academy, then so does the "lumping" of a beneficiary challenging the entirety of a physician's submission to Medicare along with claimants attempting to increase their awards, merit no less of a result. The challenged regulation, §405.817(a)(1) *infra* impermissibly combines two different groupings within its classification, to the constitutional detriment of petitioner estate which is being denied its claimed right to an ALJ hearing in this matter.

II. Federal judicial review of the within matter can be sustained under 28 U.S.C. §1331, 42 U.S.C. §405(g) or 42 U.S.C. §1395ff(b)(2)(B).

The Supreme Court has stated that 42 U.S.C. §405(h) "purports to make exclusive the judicial review method set forth in §405(g)." Shalala v. Illinois Council on Long Term Care, Inc., 529 U.S. 1, 10 (2000). The second sentence of the statute

states that "[n]o findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided." §405(h). Its third sentence states that "[n]o action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to *recover on any claim* arising under this subchapter." Id. (Emphasis added).

As defined in Shalala, supra, the words "to recover on any claim" apply in a typical Social Security or Medicare benefit case, "where an individual seeks a *monetary benefit* from the agency (say, a disability payment, or payment for some medical procedure), the agency denies the benefit and the individual challenges the lawfulness of that denial. The statute plainly bars §1331 review in such a case, irrespective of whether the individual challenges the agency's denial on evidentiary, rule-related, statutory, constitutional , or other legal grounds." Id. (Emphasis added). Though the actual question in Shalala, supra, dealt with the case-specific issue of whether a future, prospective challenge to a regulation constituted an action "to recover on any claim arising under" the Medicare or Social Security Acts, the definition of the phrase covers the case, *infra.*

The simple fact of the matter is that petitioner-estate is *not* attempting to recover a monetary benefit from the agency, but to the contrary, is attempting to *void* one. As previously explained in the Statement of Facts, infra, petitioner has already received a benefit in the form of an award of Medicare monies to the primary care physician he hired (Tucker) for the March 30 to April 7, 2000 period in question and the estate should not have to be obligated to pay for an additional primary care physician (Profeta), who resigned and was replaced by the former for the designated period of time. Such a result surely violates 42 U.S.C. §1395y(a)(1)(A), which states that "no payment may be made under Part A or Part B * * * for any expense incurred for items or services * * * which * * * are

not reasonable and necessary for the diagnosis or treatment of illness or injury." Id.

Consequently, because petitioner-estate is not seeking to recover a "monetary benefit" from Medicare, the third sentence of §405(h) barring a §1331 action against the Secretary in not applicable to this case, and the federal courts may exercise §405(g) jurisdiction herein, as occurred in Matthews v. Eldridge, 424 U.S. 319 (1976). As discussed in Shalala, supra, Eldridge "is a case in which the Court found that the respondent *had followed* the special review procedures set forth in § 405(g), thereby *complying with*, rather than *disregarding*, the strictures of § 405(h). See *id.*, at 326-327 (holding jurisdiction available only under § 405(g)). Id., at 15. (Emphasis in the original). The Court, in Shalala, supra, found that "§ 405(g) contains the nonwaivable and nonexcusable requirement that an individual present a claim to the agency before raising it in court * * * [t]he Council has not done so here and thus cannot establish jurisdiction under § 405(g)." Id.

Not so with the estate, *infra*, which has presented its claim to the agency challenging 42 CFR §405.817(a)(1), in addition to the merits of its case, *before* it was presented to the District Court for review. Hence, the estate is not barred from asserting jurisdiction under §1331 for judicial review, as well as §405(g), in accordance with the decision in Matthews v. Eldridge, supra.

In addition to the above statutes, petitioner estate is eligible for review under 42 U.S.C. §1395ff(b)(2)(B), upon court waiver of the statute's $1,000 jurisdiction threshold. Such waivers are not unknown in district courts. In Bartlett v. Heckler, 576 F.Supp. 830 (D.C.D.C. 1983), the plaintiff challenged 42 U.S.C. §1395x(y)(2)(B), which denied "reimbursement to a patient receiving extended care services in a non-Christian Science nursing facility if, during the same spell

of illness, the patient previously received extended care in a Christian Science facility." Id., at 831. Plaintiff-executrix, whose amount-in-controversy was only $286.00, could not meet the jurisdictional minimum of $1,000 for judicial review and argued that the "different standards violate[d] the free exercise clause of the First Amendment and the equal protection and due process clauses of the Fifth Amendment." Id., at 831.

Relying on Johnson v. Robinson, 415 U.S. 361 at 366-367 (1974), the court concluded that if all judicial review of plaintiff's claims were precluded, "the most serious constitutional questions would be present. The Court has, of course, a duty to avoid such questions if it is possible to do so." Bartlett, supra, at 833. The Court concluded that, despite plaintiff's failure to satisfy the $1,000 jurisdictional minimum, that it could exercise general question jurisdiction under 28 U.S.C. §1331 "because plaintiff's claim is based on the Constitution and because there is no alternative method of securing judicial review of her claim. Id. at 831. (Emphasis added). *See also:* McCuin v. Secretary of Health and Human Services, 817 F.2d 161 (1st Cir. 1987) (affirming a decision of the District Court for New Hampshire holding that the district court possessed jurisdiction over a challenge to administrative interpretation of the Secretary's reopening regulations under either mandamus or federal question jurisdiction, although plaintiff did not meet the $1,000 minimum for judicial review). The First Circuit held that "jurisdiction is particularly appropriate here in view of the constitutional challenge to the Secretary's interpretation of the regulations." Id.

Petitioner estate is in an identical position, challenging a regulation of the Secretary on constitutional grounds. The estate has asserted jurisdiction under 42 U.S.C. §1395ff(b)(2)(B) in its Third Amended Complaint *infra* and submits that it is similarly entitled to a waiver of the $1,000 threshold minimum for judicial review.

The Third Circuit Court of Appeals is not unfamiliar with the applicability of §1331 federal question jurisdiction to matters not within the statutory jurisdiction of Medicare hearing officers. In Medical Fund-Philadelphia Geriatric Center v. Heckler, 804 F.2d 33 (3rd Cir. 1986), the Third Circuit reinstated a suit to "permit the plaintiff to amend its complaint to allege jurisdiction under 28 U.S.C. §1331." Id., at 35. The appellate court decided that what plaintiff was actually claiming was that by requiring "place of service of plaintiff's professional services as a condition of payment, to be performed in a Medicare-certified facility, which, in fact, is already Medicaid-certified, is agency rule-making *in excess of statutory authority*" Id., at 38. (Emphasis added). The Third Circuit deemed these implied assertions to amount to a claim that the Secretary's position was "contrary to law." Id.

Similarly, in American Ambulance Service v. Sullivan, 911 F.2d 901 (3rd Cir. 1990), the Third Circuit reversed a dismissal for lack of subject matter jurisdiction in a case where the plaintiff-provider's challenge to a Medicare Part B recoupment determination was deemed a challenge to the rule, itself. In its decision, wherein it deemed appellant's challenge to Medicare reimbursement methods a "colorable" one, id., at 910, the Court quoted from Michigan Academy, supra:

> "[M]atters which Congress did *not* delegate to private carriers, such as challenges to the validity of the Secretary's instructions and regulations, are cognizable in courts of law."

Michigan Academy, supra, at 680. (Emphasis in original).

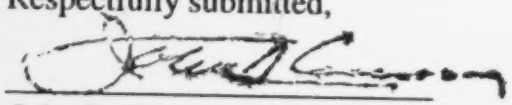
Petitioner's constitutional challenge to 42 CFR §405.817(a)(1) merits a similar jurisdictional result in the Third Circuit, under circumstances wherein there is no bar to the

introduction of petitioner's DNR order (App. N at 59a) into evidence on the dispositive issue of which of the two doctors was decedent's primary care physician during the March 30 - April 7, 2000 period at issue.

CONCLUSION

For reasons aforesaid, Petitioner prays that the Supreme Court should grant the estate's petition for certiorari and issue its writ to the Third Circuit Court of Appeals.

Respectfully submitted,



John R. Connor, Executor pro se
Estate of Helen T. Hanlon

Dated: 16 March, 2005